

ILLINOIS PROVIDER ENROLLMENT



Provider Modifications

Log-in to IMPACT

***User ID**

***Password**

Login

[Forgot your password?](#)

[Need Help?](#)

Don't have an account?

Create New Account

- Enter the *User ID* and *Password* then, click *Login*.

Log-in to IMPACT

Manage your account



Request Application Access



Update Profile



Change Password



Update Security Q&A

Access your applications

- [IMPACT Provider Enrollment](#)

- Click on the hyperlink, ***IMPACT Provider Enrollment***.

Modifying an enrollment

A screenshot of a web application interface showing a dropdown menu. The menu is open, displaying three options: "Jones Steve" (highlighted in blue), "Doe John", and "Medical Assocs INC.". Below these options is a "Select Favorites" option. To the right of the dropdown is a "Go" button. A red arrow points to the top of the dropdown menu.

- From the first drop down, choose the provider name of the enrollment that needs modified.

Modifying an enrollment



Illinois Medicaid Program Advanced Cloud Technology

IMPACT

Jones Steve ▼ *

Select Profile ▼ ←

- Select Profile
- Domain Administrator
- Provider Enrollment Access**
- View Provider Enrollment

Go

- From the second drop down, select **Provider Enrollment Access**, then click **Go**.

Modifying an enrollment

The screenshot displays the IMPACT Provider Portal interface. At the top left, the IMPACT logo is visible with the tagline "Illinois Medical Program Advanced Deaf Technology". The user is logged in as WALLACH, Tracy. The navigation bar includes "My Inbox" and "Provider" dropdown menus. The "Provider" dropdown menu is open, showing options under "PROVIDER ENROLLMENT" (New Enrollment, Track Application) and "MANAGE PROVIDER" (Manage Provider Information, which is circled in red). The main content area shows a "Latest updates" section with a "Screen Legend Integration System" update. On the right, there is a "Calendar" widget for August 2015, showing the current date as Monday, August 31, 2015, at 10:54. At the bottom, the "My Reminders" section is empty, displaying "No Records Found!".

- From the **Provider** drop down, select **Manage Provider Information**.

Modifying an enrollment

Close Undo Update

View/Update Provider Data - Individual

Business Process Wizard - Provider Data Modification (Individual).

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Provider Basic Information	Required	08/20/2015	08/20/2015	Complete		
Step 2: Specialties	Required	08/25/2015	08/20/2015	Complete		
Step 3: Associate Billing Provider	Required	08/20/2015	08/20/2015	Complete		
Step 4: License/Certification/Other	Required	08/20/2015	08/20/2015	Complete		
Step 5: Provider Controlling Interest/Ownership Details	Optional	08/20/2015	08/20/2015	Complete		
Step 6: Taxonomy Details	Required	08/20/2015	08/20/2015	Complete		
Step 7: View Servicing Provider Details	Optional	08/20/2015	08/20/2015	Complete		
Step 8: Associate MCO Plan	Optional	08/20/2015	08/20/2015	Complete		
Step 9: Complete Modification Checklist	Required	08/20/2015	08/20/2015	Incomplete		
Step 10: Submit Modification Request for Review	Required	08/25/2015	08/20/2015	Incomplete		Modification Request has not been Submitted.

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- Click on the hyperlinked step(s) that need updated and make the necessary adjustments.

Modifying an enrollment

Close Undo Update

View/Update Provider Data - Individual

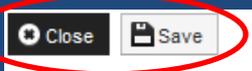
Business Process Wizard - Provider Data Modification (Individual).

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
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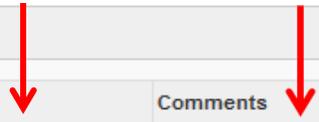
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- After making all necessary updates, click on **Complete Modification Checklist** and answer the provided questions.

Modifying an enrollment



Manage Provider Checklist		
Question	Answer	Comments
Do you need to request a Retroactive Enrollment Date? If Yes, enter the requested Retroactive Enrollment Date in the comment field to be considered.	Not Completed <input type="button" value="v"/>	
Do you wish to end date your enrollment? If yes, what date?	Not Completed <input type="button" value="v"/>	
Are you currently excluded from any Illinois or other state program? If yes, provide state of exclusion and program.	Not Completed <input type="button" value="v"/>	
Are you currently excluded from any federal program? If yes, provide the program and date.	Not Completed <input type="button" value="v"/>	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date.	Not Completed <input type="button" value="v"/>	
Have you ever had a judgment under any false claims act? If yes, list judgment and date	Not Completed <input type="button" value="v"/>	
Have you been certified or recertified by Medicare within the last year. If yes, provide date.	Not Completed <input type="button" value="v"/>	
Have you been certified by another State's Medicaid Program. If yes, provide each state and effective date of certification.	Not Completed <input type="button" value="v"/>	
Have you ever had a program exclusion/debarment? If yes, provide program and date	Not Completed <input type="button" value="v"/>	
Have you ever had civil monetary penalty? If yes, provide penalty type and date.	Not Completed <input type="button" value="v"/>	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership	Not Completed <input type="button" value="v"/>	



- Each question needs answered with a **Yes** or **No**. Enter **Comments** as necessary. If a question does not apply, choose **No**.
- When completed, click **Save**, then **Close**.

Submitting a modification

Close Undo Update

View/Update Provider Data - Individual

Business Process Wizard - Provider Data Modification (Individual).

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- When the modification checklist is completed, click on **Submit Modification Request for Review**.

Submitting a modification

Close Next

Final Submission

NPI: 1679968283 EnrollmentType: Individual/Sole Proprietor

The Information submitted shall be verified and reviewed by the State.
During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct. (Private and Confidential)

Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
▲▼	▲▼	▲▼	▲▼
No Records Found !			

- Read the posted statement, then click **Next**.

Submitting a modification

I, the undersigned, after a general psychiatric residency program or a child/adolescent psychiatric residency program, I agree to provide IHS with the name of the program and the date on which I completed the program. I further agree that my acceptance of these Terms and Conditions certifies, under penalties of perjury, that the information I have provided on my residency program is true, accurate and complete.

Alcohol and Substance Abuse Providers

Alcohol and substance abuse providers in the Illinois Medical Assistance Program agree, represent, and certify as follows:

1. I shall notify Illinois Medical Assistance of any significant injury, suicide attempt or death at the facility, in order to allow Illinois Medical Assistance and the Department of Public Health to investigate the incident.
2. The Provider, if a substance abuse treatment and intervention provider per the definitions and requirements of 77 Ill. Admin. Code 2060 and 2090, agrees that it will maintain compliance with applicable parts of the then-effective Attachment C to the Department of Human Services Community Services Agreement (available via <http://www.dhs.state.il.us/page.aspx?item=29741>).

Community Mental Health Providers

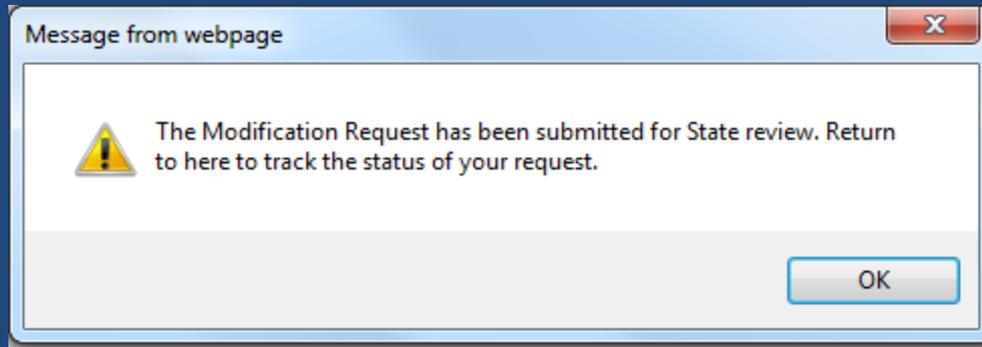
Community Mental Health providers in the Illinois Medical Assistance Program agree, represent, and certify as follows:

1. The Provider, if a community mental health provider per the definitions and requirements of 59 Ill. Admin. Code 132, agrees that it will maintain compliance with applicable parts of the then-effective Attachment B to the Department of Human Services Community Services Agreement (available via <http://www.dhs.state.il.us/page.aspx?item=29741>).

By checking this, I certify that I have read and that I agree and accept the enrollment conditions in the Trading

- Read through the terms and conditions. Scroll down and click the checkbox to agree, then click **Submit for Modification**.

Submitting a modification



- Click **OK** on the message box.

Close Undo Update

View/Update Provider Data - Individual

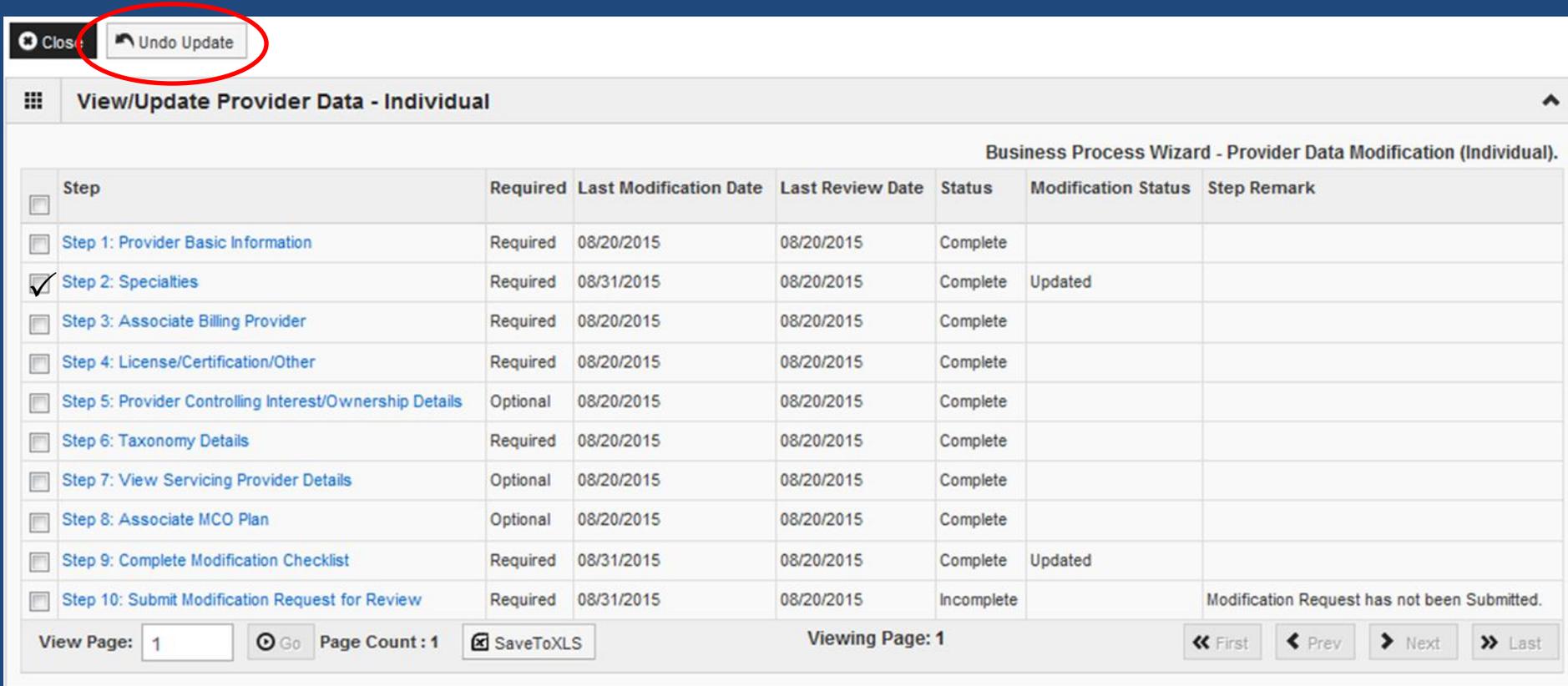
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- **Modification Status** will show the status of the review of the modification.

Deleting a modification



Close Undo Update

View/Update Provider Data - Individual

Business Process Wizard - Provider Data Modification (Individual).

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<input type="checkbox"/>	Step 1: Provider Basic Information	Required	08/20/2015	08/20/2015	Complete		
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<input type="checkbox"/>	Step 4: License/Certification/Other	Required	08/20/2015	08/20/2015	Complete		
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- To cancel an update prior to submitting, place a check in the box next to the line that has the update that needs deleted, then click on **Undo Update**.

Deleting a modification

View/Update Provider Data - Individual

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- When completed, click *Close*.